

To be successful, self-insurers must reduce claims costs. Technology can streamline the process and allow better control of costs.

Better Self-Insurance Through Technology

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The property and casualty insurance sector is in turmoil. Not only has the industry experienced an unbelievable run of catastrophes and terrible investment performance, but it is also experiencing serious problems in regard to its reserves. In every direction, the industry is being hit by the worst possible combination of factors, forming what many industry experts have commonly termed a “perfect storm” that is wreaking havoc on insurers’ bottom lines.

Premium prices have moved up anywhere from 10 percent to 25 percent, all the way up to 300 percent or 400 percent, depending on the particular insurance line and geographic location of the insured.¹ It has been difficult for large employers with relatively clean claims records to swallow these substantial premium increases. Companies are justifiably asking

whether their risk profiles have increased proportionately to their rates or whether they are simply paying for insurers’ bad pricing practices of the past.

All these factors are driving organizations to seek alternatives, with many looking at self-insurance as a way to directly control and manage claims costs and to avoid high insurance premiums. In order to determine if self-insurance is appropriate for certain lines and industries, it is important to first understand the various factors influencing the market. Organizations can then make critical decisions on whether to self-insure and how to execute a successful self-insurance program.

Tremendous Losses and New Risks

In the late 1980s and throughout the 1990s, many

insurers cut corners to gain market share. Competitive pressures along with strong investment returns led many insurers to underprice their coverage. This strategy has caught up to insurers, and they must now apply the strictest of underwriting principles to turn a profit.

In addition, the world is a very different place: Consider the September 11 attacks, the war against Iraq, our need for constant vigilance in regard to homeland security and terrorist threats, and an increasing array of new risks, liabilities, and regulations. These issues have given many risk managers good reason to lose sleep at night. In order to properly plan, they need to analyze the significant factors that have led to the hard market and to consider if and how these conditions may be alleviated and managed in the future:

- *September 11 terrorist attacks.* The events on this day produced the single largest insured catastrophe to date. They sent seismic shockwaves throughout the industry that are still felt today. The Insurance Information Institute estimates the total insurance losses from September 11 will be approximately \$40.2 billion.² Another terrorist attack of this magnitude could drive insurers to the brink of insolvency and the industry as a whole to its knees.
- *Dramatic decline in the stock market and global recession.* Declining investment portfolios have reduced the funds available from an important source of income for insurers and reinsurers, forcing them to apply strict underwriting principles to achieve profitability. In addition, the global economic recession has significantly lowered interest rates and left insurers scrambling to find better investment opportunities. Many financial experts say that a market turnaround does not look hopeful anytime soon.
- *Growing litigation costs from old, new, and expanded risks.* New claims for toxic mold, asbestos, environmental liabilities, and other class-action types of exposures have all added significantly to mounting losses. For instance, long-term asbestos liabilities are estimated at \$60 billion, incurred over many years from hundreds of thousands of claims. Likewise, the insurance industry's costs for long-term environmental liabilities, such as oil spills, have been estimated at \$30 billion to \$40 billion.³
- *Staggering jury awards.* In medical malpractice, for instance, the unprecedented proliferation of large jury awards and settlements is expected to continue. As a result, most major malpractice insurers have experienced deterioration of their loss ratios. Malpractice insurance premiums have skyrocketed, and in some cases, insurers have withdrawn from markets altogether.
- *Deficient reserves.* Underpricing during the soft market caused a significant shortage in loss reserves by the end of 2000. This deficiency persists today despite the industry's efforts to increase premiums to keep pace with losses. According to a study by Conning Research & Consulting, the reserve deficiency has more than doubled from a year ago, further straining the insurers' ability to cover the rising cost of claims.⁴
- *Medical-cost inflation.* The insurance market has also felt the sting of rising health-care costs, which jumped 11.5 percent in 2001, after a steady climb of about 7.5 percent from 1996 through 2000.⁵
- *Challenging regulatory environment.* For instance, last year's Sarbanes-Oxley Act established new corporate governance rules and has made companies think very differently about their exposures, including risks they never considered before.
- *Meltdown of corporate governance.* Corporate scandals in the United States involving Enron and WorldCom will involve significant insured losses. The real problems will come from lawsuits. Enron liability lawsuits are going to be huge, with more than 300 suits filed last year on claims of artificial inflation and accounting fraud. The average settlement is already above \$20 million.⁶

- *Financial stress experienced by individual insurers and reinsurers.* All the above factors contributed to a weakened balance sheet for many insurers. By December 2002, Standard & Poor's had cut the ratings of 47 players and upgraded only 3.⁷ A major concern for risk managers today is the financial stability of their insurers.

Difficult Conditions for the Insured

Industry experts say we're well into the second year of the hard market. Some money is flowing back into the industry — mainly in the form of increased premiums. But not only has insurance become expensive, it has also become hard to get. Tightening has occurred in the exclusions included in contracts, especially in regard to acts-of-war and terrorism coverage.

Fewer insurers are willing to take on specific risks in certain industries. For instance, in some businesses or professional practices, liability insurance is either prohibitively expensive or completely unattainable. Some insurers have exited lines and states altogether. Now, with many coverage areas no longer available, many companies are being forced to find alternative risk-financing solutions.

With terms and conditions tightening, litigation between insureds and insurers has also increased, with many companies discovering that simply having insurance does not guarantee that losses are covered. Today, an increasing number of claims are being denied, whereas in the soft market, insurers often decided in favor of the insured when there were doubts over coverage.

Today, insurers are denying claims with little investigation and sometimes on questionable grounds, even challenging relatively small claims that fall into gray areas. Some believe this change in how insurers handle claims is directly related to their attempts to improve their profitability.

Conditions in the reinsurance market have also created a trickle-down effect on commercial insurance buyers. Many reinsurance clients are seeing 15 percent to 25 percent price increases in the professional liability and workers compensation lines. Insurers are not able to get reinsurance at the same attachment points or limits. Whereas a retention previously might have been imposed at \$250,000,

now it is at \$500,000. In addition, entire coverage can often be capped, for instance at \$20 million.⁸ This means insurers are liable for more of their own losses, which has led to further price increases.

Move to Retain Risks

Insurance buyers have prepared their chief financial officers for the worst-case scenario, suggesting that the only affordable options may be to retain more risk or to seek alternative risk transfer solutions.

Traditionally, businesses and organizations have handled risk by transferring it to an insurer through the purchase of an insurance policy. In general, as premiums and retentions increase so does the rate of self-insurance.

An increasing number of employers have either moved into a self-insured program for the first time, increased their self-insurance limits, or expanded their self-insurance.

When a company retains risks in the form of self-insurance, instead of paying premiums to an insurer, the company simply allocates funds to cover unexpected contingencies. On the whole, self-insurance is a sound strategy, provided that a company is prepared to assume the risk, has the right risk management expertise, and has capable information technology (IT) systems in place to organize managing of the claims process and careful monitoring of costs.

Several alternatives exist for companies wanting to retain (self-insure) more of their own risks to reduce costs. Estimates on the size of the self-insurance market vary widely, due to differing definitions of what self-insurance includes. For instance, A.M. Best estimated that self-insurance represented a \$100 billion to \$130 billion industry, but according to Swiss Re, the global market for alternative risk transfer accounted for about \$88 billion in premiums in 2001. An increasing number of employers have either moved into a self-insured program for the first time, increased their self-insurance limits, or ex-

panded their self-insurance into new regions, coverage types, and divisions.¹¹

Forms of self-insurance include:

- *Self-Insured Group (SIG)*: A self-insured group consists of employers — in the same industry — that jointly pool their resources to insure one another's workers compensation exposures instead of paying premiums to an insurer or to a workers compensation state fund. Some states do not allow SIGs. In those areas, other alternative programs must be used.
- *Captive Insurers*: Captives are insurers owned by the organizations they insure. By forming their own captive insurer, organizations not only may obtain reduced premiums, but they most likely can also access economy-priced reinsurance. Another advantage is that a captive offers its corporate owners greater control over their risk exposures. If losses are reduced, the owners can keep the investment income. An additional advantage of captives is the availability of a tax deduction for the premium paid by the insureds as well as a deduction for the loss reserves.
- *Risk Retention Group/Pool*: A risk retention group (RRG) is a liability insurer that is owned by its members. Under the Liability Risk Retention Act (LRRRA), RRGs must be domiciled in a state. Once licensed by its state of domicile, an RRG can insure members in all states. Because the LRRRA is a federal law, it preempts state regulation, making it much easier for RRGs to operate nationally. As insurers, RRGs retain the risks of their members.¹³ An RRG differs from a captive in that it offers only "liability" insurance, which includes all types of third-party liability, such as general liability, errors and omissions, directors and officers, medical malpractice, professional liability, products liability, and so forth. The LRRRA does not extend to workers compensation, property insurance, or to personal lines of insurance, such as homeowners and personal auto insurance coverage. Twenty-one new RRGs were formed in 2002, bringing the total number to 90, the

highest number ever reported by the *Risk Retention Reporter*.¹⁴

- *Self-Insured Retentions*: With self-insured retentions, the insured is responsible for administration of claims within the designated SIR, including the provision of a defense. In exchange, the insured receives a lower premium. Ultimately, the insurer is responsible for the cost of those claims within the SIR. If an organization at one time carried a self-insured retention of \$10,000, that amount may now be at \$25,000.¹² One possible disadvantage is that the administering of claims may be more costly than anticipated and may involve more staff time than was initially planned. In addition, an insured is typically not obligated to accept a settlement within the SIR. This is an aspect of SIRs that concerns insurers, as an insured may take a chance with the insurance company's money.
- *High-Deductible Policies*: High-deductible policies ultimately result in an organization paying a smaller premium, but retaining more risk. The deductible represents the amount the organization must pay before the insurer is obliged to pay for claims. In workers compensation, many companies are retaining a larger portion of their risk through deductibles of \$100,000 or more. With the hard market, large deductible plans have grown in popularity. Large deductible programs account for more than 30 percent of the total workers compensation market, based on information from the National Council on Compensation Insurance (NCCI).¹⁵

The impetus behind the move to retain more risk is not just high premiums. Some risk managers are more concerned with avoiding market volatility. The shift is also due to the success employers have experienced in controlling their own losses. At many companies with self-insured workers compensation, injury rates have been dropping for years.

What Is Needed for a Successful Self-insurance Strategy?

Self-insurance is not an automatic solution to rising costs, but under the right conditions it can be

very effective. If only 30 cents of every \$1 of premium pays legitimate claims at a typical insurer,¹⁶ self-insurance provides companies with ample opportunity to save money by reducing claims and administration costs. But what are the primary considerations a company must take into account in order to ensure a successful self-insurance strategy?

There are at least three important issues that must be resolved:

1. how to handle the administration and processing of claims to ensure optimal efficiency and cost-savings;
2. how to ensure the right IT systems are in place; and
3. how to analyze risks in terms of key performance indicators, such as claims severity, frequency, and average duration of a claim.

Who Will Handle Claims?

If a company is coming to self-insurance from a fully insured environment, there is an obvious staffing issue regarding who is going to handle claims processing. This leads to the age-old debate of whether to self-administer claims in-house or to farm out this process to a third party administrator (TPA).

Self-administering claims would mean hiring the necessary staff and experts to manage claims and obtaining claims administration software and IT infrastructure to process claims internally. Selecting the right TPA would mean finding an administrator that has sophisticated systems, expertise, and flexibility to work with individualized needs.

There are distinct advantages and disadvantages to both methods, and the decision basically boils down to an organization's culture and values: Does the company want more or less "control" over the claims process? These days, many companies, particularly those that may be attempting to improve upon or expand their previous self-insurance program, want *more* control over both their claims data and their claims-handling procedures.

In order to obtain this control, many companies choose to self-administer claims. Companies that select this method utilize the utmost care and best practices in reviewing claims and costs, realizing that each claim and bill ultimately affects their bottom

line. They also rely heavily on an effective claims administration system that allows them to maintain detailed records, manage priorities, and navigate claims through the entire process, including first report of injury, bill review, investigation, recovery, litigation, and eventually settlement.

With the scarcity of trained claims professionals, many self-insured organizations find recruiting and retaining qualified adjusters and nurse case managers to manage the claims process to be a challenge. In addition, it may be difficult to quickly obtain the space and equipment to start a claims department from scratch.

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A Hybrid Solution

As a result, a new hybrid solution has also emerged that combines the best aspects of self-administration and third-party administration. In this model, the self-insured entity licenses claims administration software and provides a TPA with remote access to the system in order to process claims.

A newcomer to the self-insurance market can relatively quickly implement the hybrid model and closely oversee the performance of the TPA via the shared claims system. Since the move to self-insurance is usually marked by a company's strong desire to determine its own destiny, this hybrid solution provides companies with significantly more options in the future. For instance, the self-insurer may decide to change TPAs, institute new policies and procedures, or bring claims administration in-house.

Companies selecting this model retain a significant amount of control over the claims process. They can generate their own reports — and not rely on a TPA to provide them. And since they own or lease the claims software, they can program the system to monitor for urgent claims and critical levels of risk. They can also institute their own claims-handling practices that the TPA would then be obliged to follow, since these practices would be programmed into the software through business rules.

For instance, when a certain type of injury occurred, the system could be programmed with a business rule to automatically set a certain reserve and to route the case to a nurse case manager to be properly managed. This type of standardization helps to make the claims process more consistent, and provides a company with direct oversight, even though a TPA is administering the claims.

Controlling Claims Costs

In either case — whether an organization self-administers or utilizes a TPA — settling and paying claims is the core business process and the single greatest expense in insurance, including self-insurance. Nearly 80 percent of property-casualty insurers' annual revenue is consumed by claims payments and loss adjustments.¹⁷

Many companies have employees distributed across the country and rely on the instant connectivity that the Internet provides.

To put a lid on claims costs, many self-insured organizations are redefining processes, implementing cost-saving procedures, and applying automation and innovation to achieve efficient, streamlined workflow at each critical step of the administration process. It's estimated that claim-settlement costs could be reduced by up to 15 percent through the use of innovative technology.¹⁸

Ideally, adjustments, processing, and communication should flow smoothly from the first report of injury to the issuance of the final payment. However, complying with regulations, remembering specific claims-handling procedures, and applying cost-saving techniques can become time consuming and result in inefficiencies, bottlenecks, and adjusters not always handling the most important task at the right time. Almost half of an adjuster's day is often spent on activities that don't directly affect the quality of a claims settlement.¹⁹

These delays and friction points can be eliminated by automating and streamlining with the use of sophisticated claims-administration software. Over-

head functions currently consume 40 percent of the time spent in handling claims; automation can reduce that time by up to 50 percent.²⁰

However — Buyer Beware!

Today, many claims systems promise a lot but deliver very little in terms of improved operations or cost savings. Many systems are not designed with the functionality and features consistent with the methods adjusters and claims managers actually use to manage claims. They also lack the flexibility to adapt to an individual organization's unique claims-handling procedures. The quality of the claims process depends not only on having the right tools but also on having an application that is highly customizable to meet an organization's unique cost-containment objectives.

The “Next Generation” of Claims Technology

Although most insurers have significant investments in claims systems that are typically 10 to 15 years old,²¹ most self-insured organizations do not have prior investments in legacy systems and are essentially starting from scratch.

From the beginning, these organizations can implement automation that will optimize their claims operations with long-term savings and efficiency in mind. For instance, many have instituted an electronic claims process, versus the traditional paper-based and labor-intensive process. This makes long-term business sense, since such a system allows a self-insured organization to process a larger volume of claims without adding more human resources.

In order to maximize automation, many self-insured companies are demanding the “next generation” of claims administration software with specific needs in mind — particularly, that the software be native to the Internet and flexible enough to adapt to today's market and unique organizational needs.

The Impact of Connectivity on the Claims Process

The Internet and increased connectivity afforded by a company's own wide-area network have certainly provided a number of powerful capabilities to increase claims processing productivity. Through the Internet, first reports of injury can be submitted immediately from any location across the country, getting claims quickly into the system so they can be better managed.

Communication between different entities in the claims process is also improved. For instance, sharing of information among claims professionals, risk managers, nurse case managers, the medical-bill review cost-containment department, supervisors, and excess insurers helps facilitate immediate action, cost control, and improved outcomes. Many companies have employees and managers distributed across the country and rely on the instant connectivity and real-time communication that the Internet or their intranet provides.

Today, the future of claims administration rests in “browser-based” software, which helps reduce bottlenecks in the claims process. Browser-based technology does not have to run over the Internet; it can run over a company’s own network or intranet. The system is referred to as “browser-based” because the only thing an end-user needs to run the application is a browser — which today is pre-packaged on most personal computers.

Many client-server applications require middleware to run over the Internet. (“Middleware” is a general term applied to any program that serves to mediate between two separate programs.) Browser-based software requires no middleware to run, making it more cost-effective, secure, and an overall improved application model. In addition, implementing a browser-based system allows a self-insured organization to utilize the hybrid solution discussed earlier.

Single-Solution Systems With Integrated Functions and Features

Efficiency and productivity gains can double when claims functions are consolidated into a single-solution claims system. This means that the software developer has taken the time and thought to carefully combine all necessary functions into one application.

For instance, traditionally, if an adjuster needed to write a piece of correspondence such as a letter regarding permanent disability, he or she would have to use a word processing application. This letter would then be saved someplace external to the computerized claims system and could not be easily tracked. With a single-solution claims system, an integrated and automated correspondence module would allow the adjuster to automatically generate letters, document and track the event, and even automatically

print the letter for optimal efficiency. That’s just one example of how a vital piece of the claims adjuster’s job can be integrated into a comprehensive application.

Another example is e-mail. Often claims adjusters must send an e-mail to an injured claimant, supervisor, or specialized claims expert. Again, this has typically been done outside of the traditional computerized claims system. Today, new single-solution software packages are incorporating e-mail into their workflow for easy execution, documentation, and tracking.

By using a single-solution browser-based application, self-insured organizations have lowered their training and installation costs.

Workers compensation medical-bill review is another good example of how one system can provide integrated benefits across the entire claims process. With this type of application, the medical-bill adjuster has access to all appropriate claim and provider data, along with any nurse case management instructions. In this way, the medical-bill reviewer can ensure that medical services have been approved and appropriately rendered; that the bills for these services are applied to the right claim; that the correct provider is paid for the services; and that the bill was adjusted based on state and national fee schedules, appropriate PPO discounts, and workers compensation regulations.

Single-solution software can attach related files, such as Word, Excel, PDFs, JPEG, or TIFF files, to a claim, allowing an adjuster to capture additional information and explanation in one place.

The examples provided illustrate how integrated functionality provides claims adjusters with the capabilities to do their work more effectively.

Transparent Consolidation of Information

At the same time that functionality is being consolidated, the transfer and management of information within such an integrated system also remain transparent. Instead of having to access multiple

software programs with different system requirements, user IDs, and passwords, users simply retrieve what they need from one browser-based application. This saves time, money, and hassle.

For instance, by using a single-solution browser-based application, self-insured organizations have lowered both their training and installation costs for software, hardware, and networking and have achieved increased information transfer, as users are more likely to utilize the system when everything is included in one place.

A good example of transparent data integration is a claims system that automatically accesses the latest labor codes, compensation rates, medical-bill repricing schedules, and PPO contracts for workers compensation. The user doesn't have to "perform" information updates, nor does the IT department have to manage multiple data interfaces.

Another important aspect of integration is how well a claims system interfaces with a company's existing technology or their vendors' systems. For instance, can the system interface with the human resources database, accounts payable application, ISO (Insurance Services Office) ClaimSearch database (to reduce the likelihood of fraud), or even with their excess insurer?

Analysis of Risks

The hard insurance market has certainly created more focus on risk management. As a result, many companies have wanted a formalized method to determine how much risk they can afford to retain, and, if they decide to purchase an insurance policy, what price breaks they can expect if they retain some risk through a high-deductible or high-retention policy.

Until recently, few organizations have had systems in place to capture the full range of data that would allow them to make important risk management decisions, analyze losses, and understand the effectiveness of current risk management initiatives. Today's integrated claims administration and risk management systems available via browser-based technology allow organizations to have a centralized data repository from which they can monitor losses and key performance measures.

The first and most important step in obtaining truly "useful" claims and risk information is to

have an application that is easy for a vast majority of users to grasp — be they technical or non-technical personnel. Ease-of-use is an important feature that empowers users to generate their own reports, as well as to independently program business rules that monitor urgent claims activity — instead of relying on the IT department to do so. Today, a broad range of claims and risk management professionals feel comfortable working with browser-based technology, since the interfaces are familiar and intuitive.

Customization of Risk Management Reports

Because they are under tremendous pressure to control costs, risk managers are demanding a higher level of customization in their risk management reports. They need innovative ways to track losses with varying levels of detail, to pinpoint critical areas of risk, and to generate new ways to hold future costs down.

In order to do this, risk managers need more than the standard fare of risk management reports. There is a greater need to perform ad hoc reporting that allows managers to analyze losses from different angles and to build actuarial triangles in order to make more sophisticated projections.

In the past, risk managers had to request this information from either their TPA or their insurer or to extrapolate the information from other basic reports they received. Today, the power of browser-based reporting allows risk managers to have direct access to real-time data and gives them the ease-of-use to generate their own reports that contain the specific, drill-down information they need. Going forward, these reports help risk managers to implement timely and expense-focused interventions that save money and improve the bottom line.

Risk Management at Every Level

By leveraging the connectivity of browser-based technology, risk management reports are also more readily accessible to a greater number of people who can help identify and manage new initiatives that control losses.

An organization with a high self-insured retention or a large deductible can use these customized reports to provide their underwriters with information that substantiates the best possible pricing. And if they still don't receive favorable premiums, these organi-

zations can then use the data to justify a move to self-insurance.

Organizations experienced in self-insurance have used customized risk management reports to tightly manage risks on a real-time basis at every level of their organization. This culture of tightly managing risks has been communicated down to onsite managers, who have a more direct impact in instituting effective loss-prevention programs and immediately handling new claims. In the case of workers compensation, onsite managers can ensure that the injured employee is receiving proper care and can continually redefine return-to-work expectations to minimize lost time. When an injured worker is able to stay at work, or when the worker returns within a few weeks, the average cost of injury is less than \$1,000. But injuries that extend beyond 30 days have an enormous capacity to increase costs, averaging about \$50,000.²²

In addition, when employees are injured, the faster they are treated and the higher the quality of treatment, the happier they will be and the sooner they can return to work, reducing claims costs. The right technology helps manage the case so a nurse case manager and other medical experts can be involved early, resulting in claims that are better managed and improving the patient's treatment and path to recovery.

Organizations that have made the investment in training managers in the use of customized risk management reports so they have the expertise, know-how, and best practices to prevent injuries from deteriorating into long-term cases can quickly see the payoff on their investment.

Real-Time Notification

Implementing risk management initiatives from the top down is important, but managing risks from the bottom up is also critical. In the past, risk managers were not always aware of problem areas in their various departments. New claims and pieces of information went unnoticed, and many risk managers were forced to essentially "fly blind" when managing their enterprise-wide programs.

One way top-level risk managers can keep up with the latest, most critical losses is to utilize browser-based business rules to ensure that they are immediately notified of the latest developments. The software can be programmed so that a self-insured organization can instantly inform its risk manager of an

urgent claim or loss through integrated tools like e-mail, wireless pagers, or cell phones. If a significant loss occurred, such as a fire, the system would instantaneously notify key decision-makers and managers about the incident, so they could initiate appropriate response measures. If a key performance indicator is at a critical risk level, real-time notification can be utilized to automatically inform the right people.

Real-time notification allows risk managers and executives to be better informed, better prepared for meetings, and compliant with statutory timelines. For instance, many tasks and functions in workers compensation run on mandated timelines. If these deadlines are not met, a public entity can be liable for penalties. With real-time notification, self-insured organizations can improve communication and thereby reduce penalties for late regulatory reporting, late payments, or late reporting on excess claims.

Conclusions

As a rule of thumb, self-insurance usually grows as premiums rise and retentions increase. With today's dramatic premium increases, many employers who have been sitting on the fence in regard to self-insurance are now more seriously considering this move as a viable means of handling risks and controlling costs.

There are many factors that point to prolonged hard market conditions. As a result, there is more pressure on risk managers and self-insurance managers to continue to improve performance, cut claims and overhead costs, and improve the overall bottom line. Many self-insured organizations are beginning to accumulate the skills to manage these programs effectively.

A key to their success has been sophisticated browser-based technology that has enabled the sharing of information with key decision-makers and managers at every level of the organization. In this way, organizations can manage their risks from the top down, as well as pushing the notification of critical risks up the management chain. After all, one bad claim can result in thousands, even millions, of dollars in losses, if the right resources and expertise are not applied.

Companies who are experienced in self-insurance, as well as those that are newcomers to the market, are looking to experienced software developers with years of experience in working in the industry and a system that has been fine-tuned through many client sugges-

tions. This type of carefully honed technology helps meet the needs of many people involved in the claims and risk management process, ultimately empowering a self-insured organization with the information to reduce and prevent losses, improve outcomes and results, and enable rapid claims management.

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About Valley Oak Systems, Inc.

Valley Oak Systems, Inc., is a privately held corporation with headquarters in Alamo, Cal. Founded in 1994, Valley Oak Systems provides technological solutions for the claims administration industry.



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